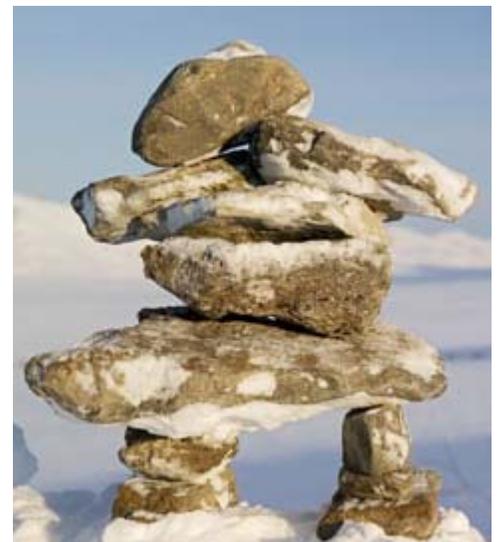




# Vision 2020: Raising the Bar in Family Medicine and Ontario's Primary Care Sector

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**JANUARY 2011**

**THE MISSION STATEMENT OF  
THE ONTARIO COLLEGE OF FAMILY PHYSICIANS:  
PROMOTING THE QUALITY OF FAMILY MEDICINE IN ONTARIO  
THROUGH  
LEADERSHIP, RESEARCH, EDUCATION AND ADVOCACY**



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## Executive Summary:

In the late 1990s, the Ontario College of Family Physicians (OCFP) undertook a yearlong consultation process that is captured in the landmark document: “*Family Medicine in the 21<sup>st</sup> Century – A Prescription for Excellent Healthcare*” ([www.ocfp.on.ca/publications](http://www.ocfp.on.ca/publications)). During the last ten years, a great deal of progress has been made in implementing in Ontario the vision of the healthcare system that was captured in the 1999 document. Our Board, however, recognized that there was a great deal more that needed to be done – and that we needed strong partnerships if we were to successfully create the system that Ontarians want and need by 2020. To this end, the OCFP has repeated the consultation process used ten years previously. With the input of family physician leaders throughout the province, the OCFP crafted a Vision for our healthcare system. The results of our strategic planning day can be found in the document “*Vision 2020: Partnering in the Quest for the “Healthcare Gold Medal”*” ([www.ocfp.on.ca/publications](http://www.ocfp.on.ca/publications)). Surveys were conducted amongst the public, healthcare organizational leaders and family physicians throughout the province (see Appendix A). In consultation with major healthcare leaders in Ontario, the OCFP identified the trends/drivers that we need to pay attention to in the next ten years and the implementation strategies that will ensure that Vision 2020 becomes a reality ([www.ocfp.on.ca/publications](http://www.ocfp.on.ca/publications) – *Summary of the Vision 2020 Symposium: Partnering in the Quest for the “Healthcare Gold Medal”*).

The “*Key Messages*” resulting from our Vision 2020 consultation process are as follows:

**Healthcare in Ontario is making a difference in the lives of Ontarians. So much more, however, needs to be done.**

**The recent Harris-Decima survey, undertaken on behalf of the Ontario College of Family Physicians, reveals that the public expects that everyone in the province will have a family physician practicing with other healthcare professionals in the near future. When all 200 Family Health Teams and other models of primary care are fully functioning, only 3.2 million people will derive the benefits from these interprofessional models of care. This means that close to 10 million mothers and babies, young children and adolescents, healthy adults and people with serious conditions, such as mental illnesses and addictions and other chronic disorders may not receive the higher level of preventive care and treatment that is provided in team-based practices.**

**Moreover, the population is aging and chronic illnesses are on the rise. We are raising the first generation of children whose life expectancy is expected to be lower than their parents. If we do not make the right investments in the system now, our healthcare system will crash under the weight of these rapidly emerging demands on our hospitals and emergency departments.**

**Enhancing family medicine is the antidote that is needed – in big cities, small towns and in remote and rural communities.**

**Over the past 10 years, impressive progress has been made at the primary care level – more family physicians have been added to the system and some of them are working in teams**

with consulting specialists, nurses, nurse practitioners and other healthcare professionals giving their patients access to a comprehensive basket of health services. Now is the time to further enhance family medicine and the primary care system so that all Ontarians are benefitting from these great changes.

It's time to raise the bar in our healthcare system so that the following are in place within the next ten years. We're calling it Vision 2020!

## Vision 2020

1. **Every person in Ontario has a family doctor.**
2. **Every person in Ontario has access to a family doctor that works in a multi-disciplinary team – so they can receive excellent care, have access to a comprehensive basket of healthcare services and avoid unnecessary visits to their local hospital emergency room.**
3. **Every person in Ontario has access to specialist input via their family doctor. Their family doctor will be part of a Network that provides “just-in-time” medical advice and continuing medical education so that family doctors are aware of the latest breakthroughs in medicine.**
4. **Every person in Ontario has an electronic health record so their healthcare providers have the information they need at their fingertips about that person's medical history, test results, current medications and more.**
5. **Every family practice in Ontario is supported through a local Family Health Quality Care Network to continually improve the care delivered to their patients.**
6. **Every Academic Department of Family Medicine has the resources it needs to educate the world's best family physicians and to serve as a hub for interprofessional education.**

**Vision 2020** is about delivering care that is focused on the patient; that is, putting them at the centre of all we do. It is about meeting many of the physical, mental, emotional and spiritual needs of individuals of all ages in one place – their own family practice. It is about family physicians and other providers collaborating and exchanging knowledge and expertise to deliver excellent care for all. It is about educating the world's best family doctors and their practice teams. It is about using valuable healthcare dollars wisely.

If we fail to make these things happen, we will experience the “black hole” in the universe of healthcare. Chronic diseases and other illnesses will consume economic and hospital staff resources at an alarming rate, in a way that is not sustainable and in a manner that is not in the best interests of our patients.

Research shows, over and over again, that healthcare systems anchored in family medicine and the primary care sector have *the best* patient outcomes at *the least* cost.

Vision 2020 has support from *so many different and relevant* stakeholders from across the system. Representatives from organizations such as the Local Health Integration Networks, the Ontario Medical Association, the Ontario Hospital Association, the Ontario Association

of Community Care Access Centres, the Registered Nurses Association of Ontario and many others actively participated in assisting the OCFP in the development of Vision 2020 and the steps we need to take to make it a reality. This groundswell of support demonstrates that we can no longer ignore the changes that are needed province-wide!

It is time to embrace Vision 2020 and to address head-on the areas that need improvement to ensure better health outcomes for Ontarians and a healthcare system that is economically sustainable.

### **The Trends and Driving Forces to be Addressed in the Next Ten Years:**

- **The Launch of an Integrated e-Health Strategy**
- **Changing Demographics - Amongst Ontarians and Healthcare Professionals**
- **Further Investments in Family Medicine/Primary Care Sector**
- **Integration of the System: Shared-Care and Collaborative Care Networks**
- **Increased Demands for Access to Care**
- **A Focus on Disease Prevention and Health Promotion**
- **Economic Restraints and Accountabilities/Buying Needed Changes**
- **The Culture and Demographics of Family Physicians**
- **A Focus on Quality Improvement**

### **The Recommended Strategies to Ensure the Successful Implementation of Vision 2020:**

- **Commit to Advocacy: Every Person Has a Family Physician and every Family Physician Practices in an Interprofessional Team**
- **Support Leadership and Interprofessional Team Development**
- **Integrate the System: Provide the Majority of Care in Family Practices/Utilize Shared-Care and Collaborative Care Networks/Establish “Specialty Referral Centres”**
- **Invest in Family Health Quality Care Networks**
- **Focus on Quality Improvement/Standardization of Performance Measurement**
- **Rollout an Integrated e-Health Strategy: Electronic Medical Records/Electronic Health Records and System-Wide Interconnectivity**
- **Develop a Health Human Resources Infrastructure**
- **Improve the Determinants of Health: Improve the Socio-economic Environment Throughout Ontario/Provide Equitable Access to Care/Balance the management of urgent problems and chronic diseases with the need to keep people as healthy as possible as long as possible.**

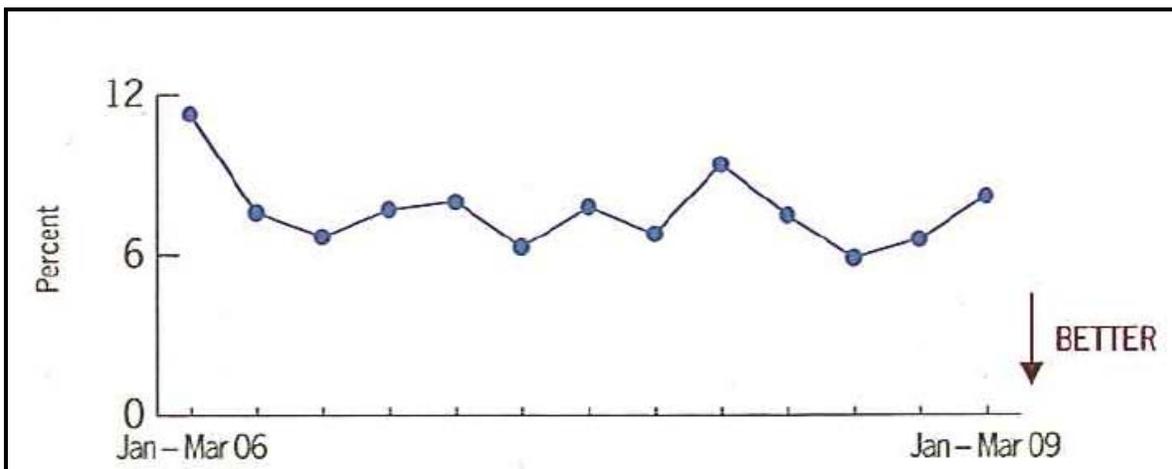
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## Fast Facts:

- **The Ontario Government is facing the double-edged sword of deficit reduction and the “tsunami of aging”. There are solutions that will ensure the sustainability of our healthcare system and they are anchored in the family medicine and the primary care sector.**
- **A recent report from the U.S.A. reveals that 30% of healthcare spending is wasted (i.e. approximately \$700 billion per year). Within the various U.S. States, some counties spend more than twice per capita on Medicare than other ones. The variability in spending is due predominantly to differences in the use of acute care hospitals as the main sites for care and to discretionary specialist visits and tests. Higher spending on these services was not found to offer overall improved health outcomes or other benefits.**
- **The governments of most developed countries have been demonstrating strong fiscal management of their healthcare systems by investing in care anchored in family medicine and primary care. Evidence indicates that their investments in family practices are affording them best value for the dollars spent. More recently, the U.S.A. has embarked on a major reform of its healthcare system, including the development of the “Medical Home” concept. Britain is radically decentralizing NHS funding through the development of “GP Consortiums” that are expected to reduce administrative costs by 45%.**
- **In Ontario, 80% of all medical care is delivered by family physicians. In spite of investments in the primary care sector during the past few years, most of our healthcare resources are provided to support care delivered in the most expensive sectors of the healthcare sectors. Our system remains hospital/specialty centric.**
- **The “Excellent Care for All” Act recognizes that poor quality care is expensive. The Act obligates each healthcare provider and the organizations that employ them to deliver high quality care. 30% of all hospital funding is utilized to support an administrative infrastructure that can be mobilized to strengthen quality assessment and improvement processes. Funding is needed to support family practices to engage more fully in the quality movement.**
- **Those jurisdictions that demonstrate the highest health system quality ratings have invested in primary care infrastructure supports. This approach has proven to be cost effective and, more importantly, has impacted positively on health outcomes such as improved access to care, decreased ER visits, hospitalizations, readmission rates and medical errors, as well as improved patient satisfaction ratings. In Ontario, most family practices have received little or no support for the infrastructure necessary to achieve these results.**
- **The Ministry of Health and Long-Term Care (MOHLTC) was on the right track in the early 2000s when it initiated the transformational agenda to stabilize family medicine in Ontario in light of the public concerns regarding their inability to find a family physician. The evidence in regards to a strong primary care system anchored in family**

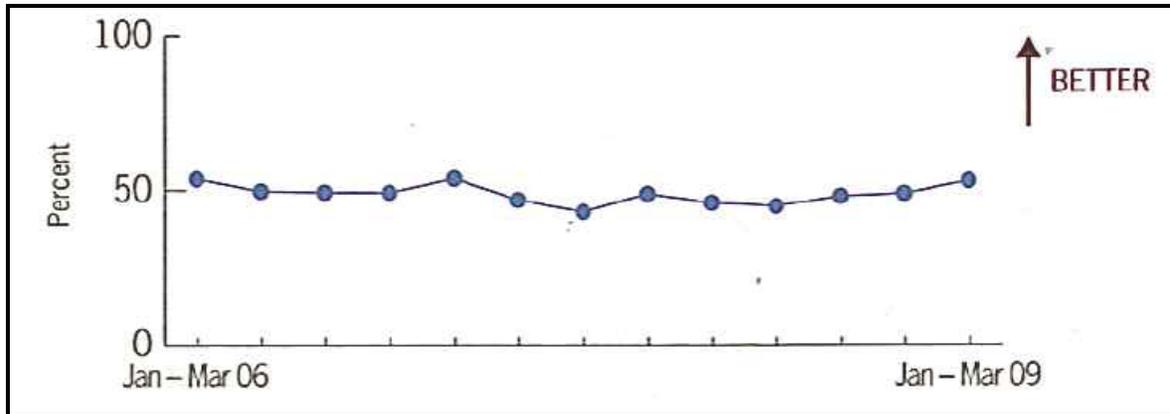
medicine and community-based care made the case for transforming the healthcare system even more compelling.

- The transformational agenda includes an increased emphasis on health and wellness through the age spans, including effective chronic disease prevention and management. A team approach has been found to be most effective in addressing the changing healthcare needs of Ontarians. The role of patients as partners in care is one of the most important variables in the success of CDPM programs. Family physicians are specifically trained to deliver patient-centred care. The patient-physician relationship is at the heart of family medicine.
- Progress has been made in the last few years to strengthen family medicine and stabilize the primary care sector; however, continuing human resource shortages in the primary care/community sector and inconsistent service delivery throughout the system continue to place undue pressure on family practices and the healthcare system, in general. The primary care sector remains fragmented and formal connections to the rest of the healthcare system are hit and miss. Given the inefficiencies in the primary care sector, it is impossible to estimate the health human resource needs with any accuracy. We do know that close to a million adults do not have a family doctor and those that do have problems accessing their family doctor in a timely way.



Note: (7.1%) Percentage of adults who are without a regular doctor, based on the Primary Care Access Survey, a quarterly phone survey of Ontario adults (aged 18 and over). Most recent results represent averaged quarterly data for the FY 2008/09 time period.

**Bottom line: There are more than 730,000 adult Ontarians without a regular doctor; over half of them are actively looking for a regular doctor, but can't find one. This has not improved in the last three years, despite increases in the supply of doctors and more Family Health Teams (FHTs).**



Note: Percentage of adults who were able to see their doctor on the same or next day the last time they were sick or needed medical attention, based on the Primary Care Access Survey, a quarterly phone survey of Ontario adults (aged 18 and over). Most recent results represent averaged quarterly data for the FY 2008/09 time period.

**Bottom line: Only half of Ontarians can see their doctor on the same or next day when sick. This has not improved in the last two years. Compared to 10 other countries surveyed, Canada and Ontario have the worst record on timely access to primary care.**

- It is estimated that 3.2 million people will be enrolled in one of the 200 Family Health Teams by 2012. Without continued investment in primary care, close to 10 million people will be denied the benefits of interprofessional team supports and more than 5600 family physicians will struggle continually to meet the needs of their patients.
- A significant number of people in Ontario still do not have a family doctor. Since the benefits of having a family physician are well-documented, the transformational agenda should not be considered complete until we reach a goal of having every Ontarian rostered in an interprofessional family practice.
- The Canadian healthcare system was built upon the values of compassion and equity (i.e. services provided on the basis of need with the most care for those most vulnerable); however, there are differential rates of access to family physicians depending upon income, education, sex and age. People with low levels of income and education are less likely to receive preventive care or monitoring of their chronic diseases. (Ontario Health Quality Council’s Quality Monitor – 2010 Report on Ontario’s Health System )

Indicator	Comparisons				Bottom line
	Income	Education	Sex	Age	
Access to primary care: – Percentage of adults without a regular doctor*	<p>Bar chart showing percentages for Income: Low (9.6), Med (6.5), High (4.3)</p>	<p>Bar chart showing percentages for Education: &lt;HS (8.3), HS (7.3), PSE (6.5)</p>	<p>Bar chart showing percentages for Sex: F (5.4), M (8.1)</p>	<p>Bar chart showing percentages for Age: 18-64 (7.5), 65+ (2.9)</p>	<p>In 2008, 6.8% of adults in Ontario were without a regular doctor. Those more likely not to have a family doctor were low income or male.</p> <p>Seniors were more likely to have a regular doctor than adults aged 18 to 64 years; this is reassuring as seniors have greater healthcare needs.</p> <p>There was no significant difference by education level and between urban and rural communities (data not shown).</p>

- Recent reports from the Commonwealth Fund, confirmed by the Ontario Health Quality Council, reveal that Ontario’s primary care sector has a long way to go to bridge “the quality chasm”. Quality improvement processes need to be embedded

into the daily work-life of healthcare professionals; however, EMRs/EHRs are essential to improving quality patient care in this sector.

### Exhibit ES-1. Overall Ranking

Country Rankings	
1.00–2.33	
2.34–4.66	
4.67–7.00	



	AUS	CAN	GER	NETH	NZ	UK	US
OVERALL RANKING (2010)	3	6	4	1	5	2	7
Quality Care	4	7	5	2	1	3	6
Effective Care	2	7	6	3	5	1	4
Safe Care	6	5	3	1	4	2	7
Coordinated Care	4	5	7	2	1	3	6
Patient-Centered Care	2	5	3	6	1	7	4
Access	6.5	5	3	1	4	2	6.5
Cost-Related Problem	6	3.5	3.5	2	5	1	7
Timeliness of Care	6	7	2	1	3	4	5
Efficiency	2	6	5	3	4	1	7
Equity	4	5	3	1	6	2	7
Long, Healthy, Productive Lives	1	2	3	4	5	6	7
Health Expenditures/Capita, 2007	\$3,357	\$3,895	\$3,588	\$3,837*	\$2,454	\$2,992	\$7,290

Note: \* Estimate. Expenditures shown in \$US PPP (purchasing power parity).  
 Source: Calculated by The Commonwealth Fund based on 2007 International Health Policy Survey; 2008 International Health Policy Survey of Sicker Adults; 2009 International Health Policy Survey of Primary Care Physicians; Commonwealth Fund Commission on a High Performance Health System National Scorecard; and Organization for Economic Cooperation and Development, *OECD Health Data, 2009* (Paris: OECD, Nov. 2009).



- **With the encouragement of the Ministry of Health and Long-Term Care, Local Health Integration Networks have begun to recognize that family physicians are the “canaries in the mineshaft.” They are the first point of contact in the system for their own patients in their family practices and provide care throughout the system in emergency departments, hospital inpatient and obstetrical units, as well as in patients’ homes and in long term care facilities. They are well-positioned to provide concrete information about what is working in the system and what is not and need to be formally engaged in system planning. LHINs are reaching out to family physicians as an essential step in system integration.**
- **Without partnerships, family physicians cannot make Vision 2020 a reality. The time is right for moving forward. The major healthcare organizations wish to work with the government to take the actions necessary to make Vision 2020 a reality by building upon the foundational work underway in strengthening family medicine and the primary/community care sector. Ontario can fall behind the healthcare cost curve or go for the gold. Let’s go for the gold!**

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## **Vision 2020: The Ingredients of a Healthcare System Worthy of an “International Gold Medal in Healthcare”**

- ❖ **Every person in Ontario will have established a trusting relationship with their own family physicians by 2020.**
- ❖ **Every person in Ontario will have access to a family doctor that works in an interdependent, multi-disciplinary team. The team collaborating with the family doctor will include other family physicians, focused practice physicians, specialist consultants, nurses, nurse practitioners, physician assistants, social workers, mental health workers, dietitians, pharmacists, CCAC case workers, home care providers, public health nurses, administrative staff and other healthcare professionals, as required.**
- ❖ **Every family practice in Ontario will provide a patient-centred and family-oriented comprehensive basket of services that focuses on keeping people as healthy as possible for as long as possible. The end result will be improved quality of life and better health outcomes for Ontarians. As well, there will be a reduced need for care in the most expensive parts of the system, resulting in the sustainability of our healthcare system.**
- ❖ **Every family practice in Ontario will work in partnership with their local Public Health Unit to address the health and healthcare needs of their practice population. In addition, they will have access to evidence-based information to advocate for changes in their communities that will improve health outcomes amongst local and regional populations.**
- ❖ **Every person in Ontario will notice a dramatic improvement in their access to care since they will be able to see their own family physician and the practice team members within 24 hours and usually on the same day. Emergency Departments will see relatively few non-urgent patients and Walk-In Clinic physicians will have joined a comprehensive family practice that provides excellent after-hours access.**
- ❖ **Every person in Ontario will benefit from the alteration in specialty referral patterns. Shared-care and “Collaborative Care Networks” will bring knowledge, skills and expertise to family practices, reducing the need for most patients to seek care in a consultant’s office or a specialty/outpatient clinic. Wherever possible, the services provided by consultants and hospital or community-based healthcare professionals will be delivered in the patient’s family practice.**
- ❖ **Admission and readmission rates for “ambulatory sensitive conditions” (i.e. subacute/chronic conditions) will be low or non-existent. Given the excellent care provided for patients with risk factors for chronic disorders or diagnosed with a chronic condition, family physicians and their teams will be able to manage these patients effectively in the community.**
- ❖ **Every person in Ontario identified as a “high resource” patient, and those on the slippery slope to becoming one, will be surrounded in their family practice by a**

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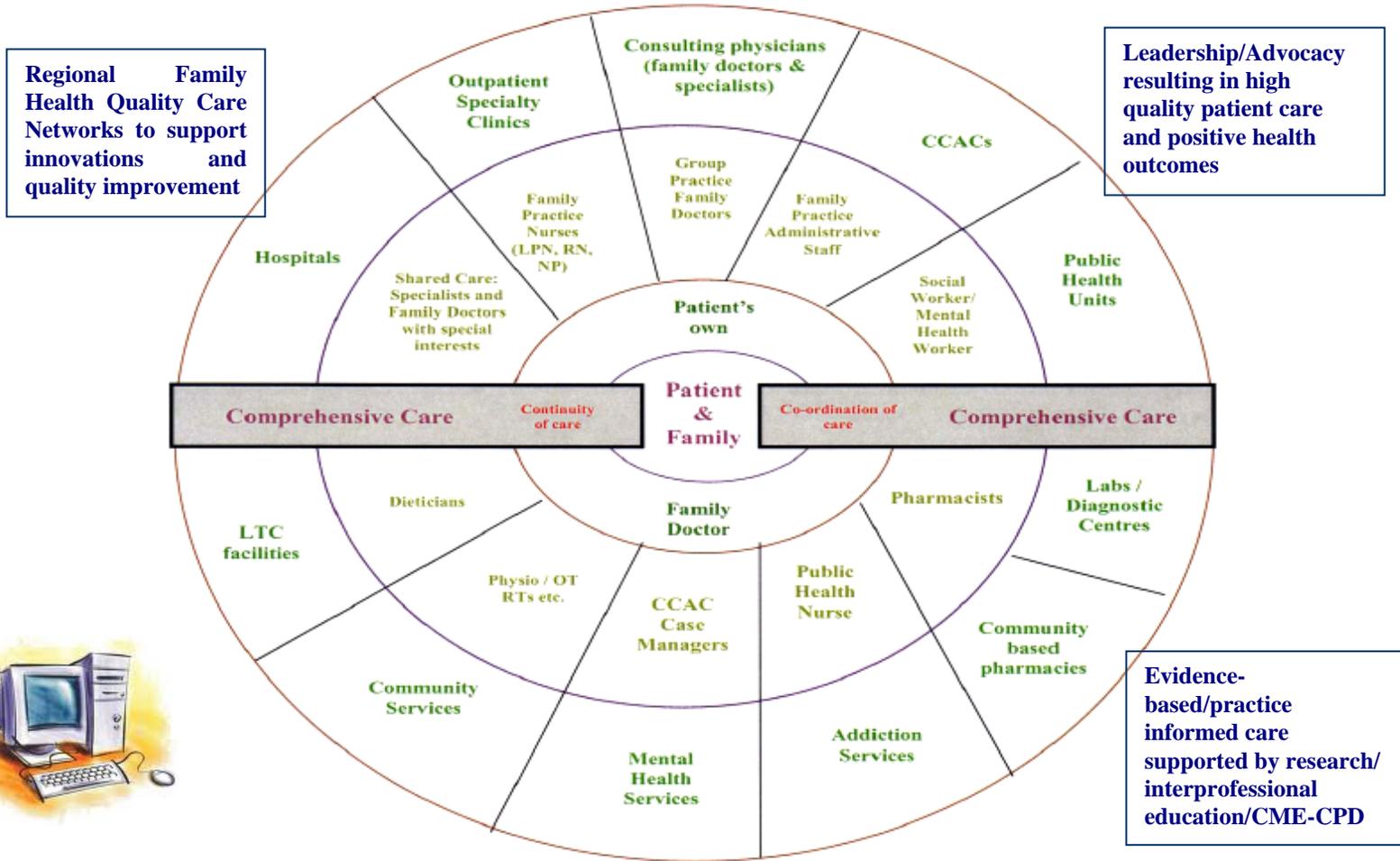
specifically designed interprofessional team. While these patients will see themselves as living well with their chronic condition(s), they will have “advanced care plans” in place to ensure that the focus of their care is on improving their quality of life, rather than attempts at “cure at all costs”.

- ❖ Every person in Ontario will have their care recorded in an electronic health record that provides the right information, at the right time, to the right healthcare provider. The EHR will be an effective enabler of team-based care, patient and provider education, quality improvement, system planning, accountability and research. With healthcare providers having access to information when needed, poor quality care, gaps in care and duplications of care that add costs to the system will be reduced. Patients will be equal partners in care and accept responsibility for their own health and for the sustainability of the system. Many encounters will not take place in family practices as technology becomes the norm to connect patients, their family physicians and their healthcare teams. Utilizing advanced technology will change the way patients interact with their family doctors and the healthcare system.
- ❖ Every person in Ontario will have timely and seamless access to the care they require from consultants, home care providers, other community-based providers, hospitals and other institutions; however, the care delivered will be coordinated by the patient’s own family physician. Family physicians will provide care throughout the system. The roles of family physicians in hospital-based care, in home-based care and in long-term care will be recognized as essential components of high quality care. Triage Centres will be established to facilitate access to care in the rest of the system.
- ❖ Every family practice in Ontario will participate in a Family Health Quality Care Network. The Quality Care Networks will have been established in every region of the province to support quality improvement activities in family practices and in the community sector in general. Effective data management systems will be in place and used to drive innovative improvements in the system. Incentives will be tied to a demonstration of quality outcomes. As family practices demonstrate (through the Quality in Family Practice Program) that they have matured, the healthcare system will include some practices and networks that have developed into “trusts” and are responsible for the judicious use of resources in the rest of the system.
- ❖ Every family practice will use evidence-based, practice-informed guidelines. Under the leadership of the Ontario Health Quality Council, an Expert Panel will have reviewed and identified tests, procedures and practices that have little or no positive impact on health outcomes or the patient experience. The elimination of such practices will have freed up funds to provide high quality, value driven healthcare. Funding will be based on patient needs, will follow the patient and funding disincentives will have been eliminated.
- ❖ Health human resources planning will be an ongoing process to ensure the right number and mix of physicians and other healthcare professionals to address the changing needs of Ontarians.

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- ❖ **Generalism will be highly regarded in Academic Health Science Centres and throughout the healthcare system. The practice and educational environments will demonstrate such a high level of support for family medicine that 45% of medical students will choose a family medicine residency program with the intention of practicing comprehensive care.**
  - ❖ **Faculty members and community-based preceptors in the Academic Departments of Family Medicine will be role models who demonstrate their expertise daily in all of the “CanMeds – Family Medicine Competencies”. Royal College residents will be afforded an opportunity to experience a block of time in a family practice. Every family practice will be afforded an opportunity to become a hub for interprofessional, interdependent team-based learning for all healthcare professional students.**
  - ❖ **Succession planning for the next generation of family physician leaders will begin in residency to ensure that each new family physician begins his/her practice with the knowledge and skills to provide excellent clinical care, to develop into superb teachers and researchers and to become healthcare leaders.**
  - ❖ **Every family practice in Ontario will receive financial support to ensure that family doctors and other healthcare professionals are able to access high quality continuing professional development programs to maintain and enhance their clinical, research, teaching and leadership skills.**
  - ❖ **Every community in Ontario will have a robust healthcare system anchored in family practices that provide educational opportunities for all healthcare learners. The Northern Ontario School of Medicine, the rural streams and the distributed learning sites will have provided excellent training for physicians in rural/community settings and will have resolved their recruitment and retention problems. Rural medicine will be highly regarded in the minds of the public and healthcare providers alike.**
  - ❖ **Every family practice will place an emphasis on work/life balance to achieve high morale amongst all team members. Family physicians and their practice team members will be envied by other healthcare professionals for their achievements in finding ways to work smarter, not harder. They will express pride in their craft based on consistently high positive patient experience ratings.**
  - ❖ **Every healthcare leader in Ontario will work together to ensure that Ontarians receive timely access to the care they need. As a result of their collaborative efforts, comprehensive, coordinated, integrated and interprofessional care, anchored in the principles of continuity of care, will be in place and Ontario will be a worthy contender for the international “healthcare gold medal”.**
  - ❖ **Supported by research garnered in Ontario, across Canada and internationally, and based on their own personal experiences, the general public will recognize the excellent care they receive in family practices and throughout the primary care/community-care sector and will applaud the government for their wisdom in recognizing the value of this sector as a key investment in the sustainability of the healthcare system. Vision 2020 will be achieved and Ontario will lead Canada in being awarded the healthcare gold medal.**

## Vision 2020:

Every Ontarian has a family physician delivering comprehensive, coordinated, integrated care anchored in the four principles of family medicine and the “Excellent Care for All” Act with the assistance of an intra- and interprofessional team. The practice team is supported by a local Family Health Quality Care Network and enabled by EMRs/EHRs, primary care research, interprofessional education, continuing professional development, including leadership and team-building skills. Leadership and advocacy activities have focused attention on the social determinates of health and equitable access to care and are producing equally positive healthcare outcomes for all Ontarian.



## 1.0) Introduction

Until the early 2000s, Canadians were convinced that they had the best healthcare system in the world; however, the cost-containment efforts in the 1990s dramatically shook their confidence in the system. Canadians began to realize that the mantra of “*doing more with less*” was simply not working. The resulting crisis in the healthcare system, especially the acute shortage of family physicians, set the stage for major investments in family medicine and the primary care/community sector. While these investments were welcomed and have had positive results, Canada still lags behind many other countries. During the 1990s, while Canada engaged in cost cutting strategies, other countries were moving away from a hospital/specialty-centric system by making major investments in general practices/primary care. International research demonstrates that those countries are now producing better health outcomes amongst their citizens and are delivering more equitable access to care for their most vulnerable populations. These improvements in healthcare outcomes are occurring with fewer healthcare dollars being spent than Canada or the USA spends on their healthcare systems.

Overall Ranking of Healthcare Systems

	AUS	CAN	GER	NETH	NZ	UK	US
Overall Ranking (2010 edition)	3	6	4	1	5	2	7
Overall Ranking (2007 edition)	3.5	5	2	n/a	3.5	1	6
Overall Ranking (2006 edition)	4	5	1	n/a	2	3	6
Overall Ranking (2004 edition)	2	4	n/a	n/a	1	3	5
Health Expenditures per Capita, 2007*	\$3,357	\$3,895	\$3,588	\$3,837	\$2,454	\$2,992	\$7,290

\* Expenditures shown in \$US PPP (purchasing power parity). Netherlands is estimated. Data: OECD, *OECD Health Data*, 2009 (Nov. 2009).

While a great deal of progress has been made in the last ten years, there is more work to do if we are to meet the needs of our growing and aging population and if Canada is to regain its title of having the best healthcare system in the world. The OCFP recognized that we needed a Vision of what healthcare should look like in 2020, as well as a blueprint of how to get there. To this end, the Ontario College of Family Physicians (OCFP) repeated the consultation process that was used in 1999. That process was the key to generating the landmark document (*Family Medicine in the 21<sup>st</sup> Century: A Prescription for Excellent Healthcare*). The OCFP’s leadership and patient advocacy activities based on the document helped to push forward the changes in the system that have been initiated in the last ten years. We were convinced that a similar process would have similar positive results.

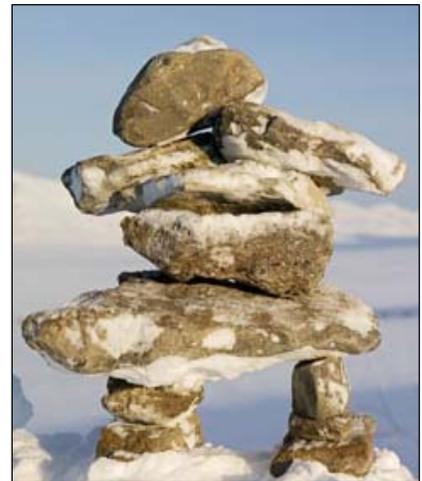
To that end, the OCFP invited key family physician leaders to join our Board during its retreat in March 2010. Vision 2020 was created at the March strategic planning event. Over the course of the summer, surveys were conducted amongst the public, healthcare organizational leaders and family physicians. On September 24<sup>th</sup>, the OCFP invited a number of acknowledged healthcare leaders from the MOHLTC, the LHINs, CCACs, hospitals, etc. to gather with family physician leaders to review the Vision for 2020 and to identify strategies for moving forward. With 140 healthcare leaders in attendance at the Vision 2020 Symposium, the dialogue was rich and meaningful. Thanks to the fireside

chats with key experts in the healthcare system and small group discussions amongst the participants, Vision 2020 was supported in principle. In addition, the participants produced several recommendations for moving forward, as well as identifying the trends/drivers of change that need to be managed in the upcoming years. The Vision, the identified trends/drivers and the recommended strategies provide government, our partners and our Members with a blueprint for moving forward to make Vision 2020 a reality.

The OCFP recognizes that Vision 2020 will be impossible to achieve unless collaborative partnerships are in place. We have chosen the Inuit Inukshuk as the symbol of our efforts to move forward collaboratively and to reinforce the concept that strength can be achieved through unity. The Inukshuk has become a symbol of leadership, cooperation and the human spirit. Ontario, indeed Canada, will achieve far greater success through cooperation and team efforts than can be achieved by individuals or organizations who choose to work independently. If we keep in mind the end goal of providing high quality care for the patients we serve, Ontario will be in a key position to implement Vision 2020 and lead Canada forward. If we do so, we will own the world's healthcare podium in 2020.

## **PARTNERING IN THE QUEST FOR THE “HEALTHCARE GOLD MEDAL”: THE SIGNIFICANCE OF THE INUIT INUKSHUK**

**THE INUIT INUKSHUK HAS EVOLVED INTO MORE THAN JUST A STONE MARKER. IT HAS BECOME A SYMBOL OF LEADERSHIP, COOPERATION AND THE HUMAN SPIRIT. EACH STONE IN AN INUKSHUK IS A SEPARATE ENTITY; HOWEVER, EACH ONE IS CHOSEN BECAUSE OF ITS ABILITY TO FIT EFFECTIVELY WITH EACH OF THE OTHER STONES. THE STONES ARE SECURED SIMPLY BY THE BALANCE THAT THEY ACHIEVE TOGETHER. EACH STONE SUPPORTS THE ONE ABOVE IT AND, IN TURN, IS SUPPORTED BY THE ONE BELOW IT. TOGETHER, THE STONES ACHIEVE STRENGTH THROUGH UNITY.**



**THIS IMPORTANT MESSAGE CAN BE TRANSLATED INTO A PHILOSOPHICAL APPROACH TO THE PRACTICE OF FAMILY MEDICINE AND THE HEALTHCARE SYSTEM IN GENERAL. THE MESSAGE FROM THE BUILDING OF AN INUKSHUK REFLECTS THE FACT THAT GOVERNMENT AND KEY HEALTHCARE STAKEHOLDERS CAN ACHIEVE GREATER SUCCESS THROUGH COOPERATION AND TEAM EFFORT THAN CAN BE ACHIEVED BY INDIVIDUALS WHO WORK INDEPENDENTLY.**

**THE INUKSHUK STANDS FOR THE IMPORTANCE OF FRIENDSHIP AND REMINDS US OF OUR INTERDEPENDENCY ON ONE ANOTHER.**

**TOGETHER, WE CAN CREATE THE HEALTHCARE SYSTEM THAT ONTARIANS WANT AND NEED.  
TOGETHER, WE CAN CREATE A LEGACY FOR OUR CHILDREN AND GRANDCHILDREN.**

## 2.0) The Blueprint for Successfully Implementing Vision 2020

The Vision 2020 Symposium was a seminal event for the OCFP and our healthcare partners. During the first “Fireside Chat”, experts in the healthcare arena provided participants with an understanding of the current state of our healthcare system and their recommendations for improving it. The second “Fireside Chat” afforded a second panel of experts an opportunity to provide us with their vision of what the healthcare system should look like in the future. In addition, the voice of the public, healthcare organizational leaders and family physicians was heard through the presentation of our survey results. A video was developed to give patients an opportunity to describe to the participants their impressions of the key roles that family physicians play in their lives. As a result of this input, it was readily apparent that Vision 2020 resonated with the participants and it was supported in principle. Through small group discussions, the participants identified the major trends and drivers of change in the next ten years. In addition, they provided the OCFP with recommended strategies to move forward so that Vision 2020 becomes a reality. None of the strategies can be implemented by government alone or by any one sector of the healthcare system. It is only through partnerships that we will ensure that Vision 2020 becomes a reality. The Vision 2020 Symposium created the climate for strong partnerships to be strengthened and to flourish in the upcoming years.

**The participants recognized that the next ten years will be challenging; however, challenging times often result in opportunities if we pay attention to the prevailing trends and driving forces.**

**The “Trends or Driving Forces” that were identified were as follows:**

### **The Launch of an Integrated e-Health Strategy**

The participants forecast that there would be an increased need for an integrated e-Health technology system with connectivity throughout the system that would be used by patients and providers alike. Today, and increasingly in the near future, consumers will be using the web to access health and healthcare information. Moreover, our patients have an expectation that EMRs/EHRs will be used by all providers, especially their family doctors, to increase safety and quality in the system at the point of care. Family physicians will need EMRs to improve performance in their practices and to measure outcomes; however, they also will need to be “connected” in order to easily access evidence-based and practice informed data and to communicate effectively when their patients receive care in other sectors of the system. Research, patient and provider education, information sharing, quality improvement and system planning will all be enhanced by EMRs/EHRs and interconnected IT systems. The participants forecast that an integrated e-Health strategy will be rolled out successful in Ontario prior to 2020.

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### **Changing Demographics – Amongst Ontarians and Healthcare Professionals**

In the next ten years, we will be facing an increase in lifestyle risks and an earlier onset of chronic diseases amongst the general population. For the first time in history, it is forecast that the current younger generation will not have as long a life expectancy as their parents. In addition, the current growing and aging population will result in an inherent increase in the number of patients with chronic disorders and multiple medical problems. Demographic influences also include a decreasing tax base, a lowered standard of living, an increase in immigration and a changing healthcare workforce with human resource shortages. The end result is potential increased costs as we deal with an increased burden of chronic disorders in the population and a strain on health human resources of all kinds and the healthcare system in general.

### **Increased Supports for Family Medicine/Primary Care to Sustain the System**

Countries with strong primary care systems have better health outcomes with lower system costs. The necessity to contain cost acceleration in a climate of growing expectations means that further investments in the primary care sector will be needed. Those investments will need to buy changes that encourage a greater emphasis on health and wellness. Evidence-based and practice informed guidelines and global information will be needed to support system reforms, to improve the quality of care in the primary care sector, to ensure system-wide support for the primary care sector and to address the trend towards increased demands in an era of decreased resources. A renewed interest in investing in the primary care sector will occur.

### **Integrating the System**

“Siloization” (i.e. the tendency to work in healthcare silos in the system) was deemed to be increasing in spite of efforts to establish a “collaborative care system”. Silo planning and the delivery of care in silos are impacting negatively on continuity of care. A collaborative, team-based system of care including system integration will be required throughout the whole of the healthcare system (i.e. primary care, public health units, CCACs, hospitals and long term care facilities). There will be an increased demand for all healthcare organizations and providers to be informed and participate in system integration and coordination within and between each sector, supported by e-Health.

### **Demands for Access to Care**

The need to improve access to care will remain a driving force in the next 10 years. A re-distribution of resources will be required. An aging population’s needs (and wants) will interact with the capacity and desire of healthcare professionals to provide equity of care across the province (i.e. the most care for those most in need). By providing more care to our most vulnerable people, we will be able to achieve equally positive outcomes for all Ontarians. This means that the additional resources needed in some parts of the province, such as our rural, aboriginal and inner city communities, to provide equitable care will impact upon the current efforts in each sector of the system to deliver equal care for each patient. The ethical dilemmas that result from the re-distribution of resources may be challenging but will be addressed effectively.

### **A Focus on Disease Prevention and Health Promotion**

The trend will be to change family practices from an “illness-based” system to a proactive practice focused on health promotion, disease prevention, early detection of diseases and chronic disease management. This may result in a clash between the need to invest time

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and resources in “upstream care” and “downstream care”. Family physicians will be challenged to investigate and manage urgent and chronic patient problems expeditiously while managing the need to focus on the health and well-being of all of their patients.

### **Economic Restraints and Accountabilities**

Given the recession, there will be a drive to economic restraints, new funding models and bureaucratic oversight of “accountabilities”. Unless there is a coordinated approach to ensure inter-connectedness, quality improvements and efficiencies, we will see erosions in the gains made in the last few years. Buying needed changes/reforms in this climate will be difficult but necessary if the system is to be sustained.

### **The Culture and Demographics of Family Physicians**

We can expect a change in the culture and demographics of family physicians as an aging physician population retires and a “sea change” in practices occurs as a new generation of family physicians used to working in teams and with technology takes on leadership roles in family practices and in the system at large. Since new family doctors are not willing to work the extended hours that the more senior physicians have been working, a medical human resource plan based on current practices will significantly underestimate the number of family physicians we will need to practice in the province. Given the preference of new doctors for team-based, EMR/EHR supported practices, non-team-based practices will be at a decided disadvantage in attracting new physicians. As the senior physicians retire from these practices, the ability of their patients to access a new family physician will be in question.

### **A Focus on Quality Improvement**

**Poor quality costs money.** An increased focus on quality improvement to ensure value for the dollars spent on healthcare will be required in each sector of the healthcare system. The participants forecast that a better alignment of professional and patient expectations with the fiscal realities would be needed to ensure value in the healthcare sector. Province-wide quality outcome indicators will need to be developed in a manner that educates patients to understand “wants” versus “needs”. With quality outcome indicators and patient satisfaction driving the system, there is a strong hope that we will see the influence of the media lessened, a reduced “McDonald’s mentality” and the fear of death replaced by appropriate end-of-life use of resources.

**Based on a review of the trends and driving forces, the participants identified a number of strategies that would enable the implementation of Vision 2020 and help to raise the bar of care in Ontario.**

***The Recommended Strategies are as follows:***

**Advocacy - Every Person Has a Family Doctor**

**Every Family Physician Practices with a Team**

There is strong evidence of the importance of having a family doctor on the health of individual patients and the population at large. In addition, the cost of a system is reduced when the majority of care is provided in family practices. The stakeholders should speak out strongly to ensure that every person in Ontario has a family physician that is supported by an interprofessional team. Prompt access to primary care teams providing a comprehensive basket of services and continuity of care was seen as the key to the sustainability of the healthcare system.

**Invest in Leadership and Interprofessional Team Development**

A comprehensive basket of services delivered in family practices focused on both health and healthcare is required to meet the needs of Ontarians. While investments are still needed in evidence-based secondary prevention and chronic disease management, increased resources need to be directed towards the primary prevention of chronic disease to decrease the incidence of disorders in the population. Interdependent teams are required to deliver the level of care that every person in Ontario needs and wants. Interprofessional, interdependent team-based care requires a focus on leadership development and team-building expertise to achieve the full benefits of care that is anchored in health protection, health promotion, the early detection of disease and the effective management of acute and chronic conditions.

**Integrate the System/Invest Further in Shared-Care/Collaborative Care Networks**

A system that unifies primary care, public health units, CCACs, community-based service organizations, hospitals and long-term care facilities is needed to improve health outcomes, to avoid gaps and redundancies and to improve access to needed resources for patients. This can be accomplished by ensuring that the majority of care is delivered in the patient's own family practice. The practices should increase their concentration on health promotion and prevention from the prenatal stage of life to end-of-life. By bringing the expertise of consultants and other hospital and community-based professionals to family practices utilizing the building blocks of the shared-care model and Collaborative Care Networks, patients can reap the benefits of "one-stop shopping". When care is needed in the broader healthcare system, the services should be better organized so that emergency departments do not continue to be the point of entry for vulnerable patients, such as the frail elderly and individuals with mental illnesses and addictions. To accelerate access to specialty or adjunct care, a system should be created to help family physicians navigate specialty/secondary/tertiary referral options. Regional or province-wide "triage centre(s)"

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that provide guidance and support for referrals and transfer to care should be established, and would be especially useful in our northern communities.

### **Invest in Family Health Quality Care Networks**

Funding is required to develop an infrastructure for the primary care sector in each region that would plan and implement an integrated primary care sector capable of continually delivering high quality care. In order to improve system integration in communities and to support the adoption of best practices, effective governance, administration and managerial structures are needed with the capacity to assess and evaluate the current system and the capacity to support the rollout of IT and CQI in every family practice in the province. The “*Australian Divisional System*” has been identified as a potential model. While the infrastructure needs to be regionally based, it will require provincial organizations such as the MOHLTC, LHINs, OHQC, OCFP, OMA, OHA and OACCAC to be involved in organizing and supporting the regional infrastructures. Each regional structure will need to use a participatory governance model to give voice to family physicians and their practice team members. This will allow them to take collective responsibility and accountability for the care provided in the regional primary care sector and in their own practices. These organizations will create system goals that are reflective of primary care but would require the input/support of each of the other sectors to accomplish each goal.

### **Focus on Quality Improvement/Standardization of Performance Measurement**

In addition to an infrastructure to support the delivery of high quality care in the primary care sector, a system-level strategy is needed to standardize performance measurement and practice management of the quality agenda. The quality of care will be advanced in primary care by investments in primary care research, the development of evidence-based and practice-informed guidelines, interprofessional education for all healthcare learners and continuing medical/health education including coaching/mentoring for family physicians and their practice team members. Specific supports are needed to implement the Quality in Family Practice program including the provision of quality improvement training and for the monitoring of primary care specific quality measures.

### **Rollout of Electronic Medical Records/Electronic Health Records**

A robust EMR/EHR system is needed for sharing information, for data collection to support the measurement of quality outcomes and to support evidence-based and practice-informed best practices. The EMR must be more than simply a digital paper record but must be able to function as a decision-support tool, a system for collecting meaningful data and metrics, a patient education tool and as the enabling tool for system integration. The information in the “electronic patient-centred chart” must follow the patient throughout the patient’s journey in the healthcare system. Patient portals with access through the EMR need to be available as we take advantage of this digital age to better support patient self-management of their own health and their various conditions. EMRs/EHRs are essential tools to improve the quality of care for patients, as well as care coordination and communications between interprofessional providers and organizations. It will take political will to accelerate the use of EMRs/EHRs across the continuum of care. While funding will be needed to invest in the e-Health strategy, there also is a need to require IT system uniformity, integration and operability to replace the current systems that lack interoperability and conductivity.

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### **Develop a Health Human Resources Infrastructure**

Processes need to be developed to identify community needs. Health human resource planning is required to anticipate those needs and train the right healthcare professionals to meet those needs. The HHR infrastructure needs to support practitioners to develop leadership and change management skills to foster a culture of quality improvement that meets the changing needs of a population over the course of time.

### **Invest in Improving the Determinants of Health**

The leadership and advocacy of all healthcare professionals and their organizations should be used to support all levels of government and the private sector to address the need to improve the social determinants of health. While family practices and the primary care sector should play key roles in addressing the determinants of health, the healthcare system alone is insufficient to improve population health outcomes. Family practices will need to balance their obligations to the provision of urgent care and the needs of people with chronic disorders with their need to assist their patients to stay as healthy as possible as long as possible. Equitable distribution of resources and an emphasis on the socio-economic environment in each community in the province will be needed to ensure equally positive health outcomes for all Ontarians.

## **3.0 Summary**

Ontario has made a great deal of progress in addressing the crisis in family medicine. While our healthcare system is heading in the right direction, there is much more that is needed if we are to achieve the positive health and economic outcomes seen in other countries. As a direct result of our lag time in investing in family medicine and the primary care sector in general, our health outcomes have been deemed to be inferior to many other countries and our per capita costs remain higher.

*We have all the building blocks in place to create a world-class healthcare system worthy of a gold medal in healthcare by 2020. Vision 2020 is within our reach – and the OCFP and our partners have created the Blueprint to make it happen. In keeping with the symbol of the Inuit Inukshuk, the collaborative efforts of the government, the OCFP and our many partners will result in Vision 2020 becoming a reality. The Stars are aligned to ensure our success.*

# **Appendix A**

## **Survey Results**

## Survey Results

During the summer of 2010, the Ontario College of Family Physicians (OCFP) commissioned a survey of the public that was conducted by Harris/Decima. In addition, a survey was conducted amongst the leaders of the major healthcare organizations and associations in Ontario. A third survey was conducted amongst the Members of the OCFP. The following provides an overview of the results of those three surveys:

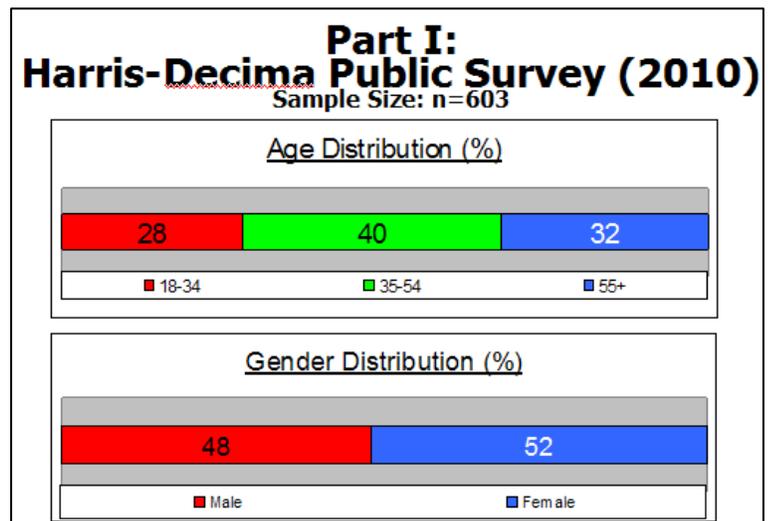
### The Survey of the Public

#### 1.0) Overview:

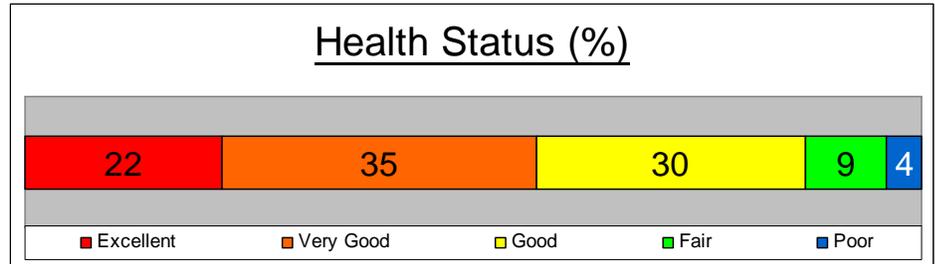
While the provincial government is struggling to address the results of the economic downturn and is extremely concerned about the ability of the healthcare system to meet growing healthcare needs in an era of cost-containment, the public survey reveals that Ontarians expect even better access to care in the future. While the survey indicates that the number of respondents without a family doctor is dropping (from 15% to 10%), 85% of people expect the government to “ensure that they and their family members have a family doctor in the future”. Of those surveyed, 91% expect that the majority of their care will be provided in their own family doctor’s office and they expect that nurses, nurse practitioners, physician assistants and other healthcare professionals will be working in collaboration with their own family physician. 87% expect that their healthcare record will be electronic and 93% want it easily accessible to their family physician and other healthcare providers. The majority of respondents that were pessimistic about the system’s ability to provide access to their own family doctor do not have one now and were resigned to having their care delivered in the more expensive parts of the system; namely Walk-In Clinics, Emergency Departments and Specialists’ Clinics. The respondents believe that the most important thing that the government could do to improve the system would be to increase the number of family doctors, nurses and specialists, improve access to care and decrease wait-times. The survey provided insights into the healthcare status of respondents, including the burden of illness amongst them.

#### 2.0) Public Survey Results:

The public survey was conducted in late August of 2010 by Harris/Decima. The age and gender distribution was representative of the general population of Ontarians over the age of 18 and the sample size ensured that the confidence level was +/-4.0% 19 times out of 20 (total Ontario).

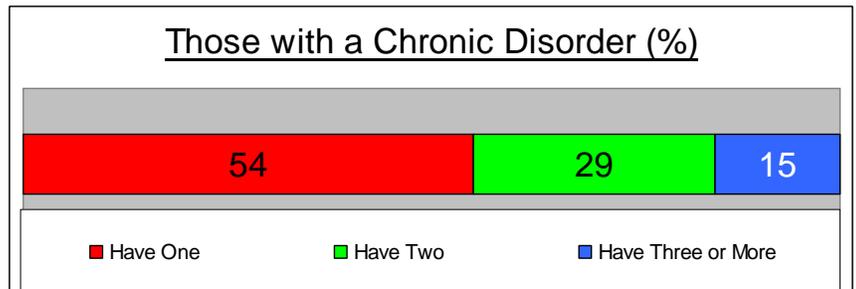
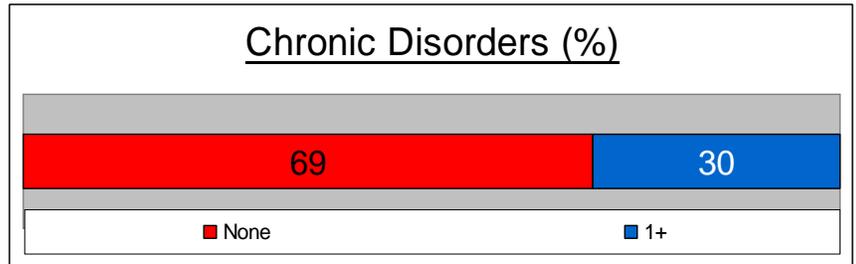


The majority of respondents reported excellent, very good or good health; however, 13% reported that their health was only fair or poor. Age was a factor in the reports regarding fair/poor health; however, a finding of 8% amongst young adults and 10% amongst the middle aged groups emphasized the need to pay attention to health throughout the age spans. The results indicate that males and people living in rural communities are more likely to report that their health is poor. Unfortunately, 6% of those reporting fair/poor levels of health do not have a family doctor. Chronic disorders tend to be a frequent finding amongst those reporting fair/poor health. 38% of those reporting a chronic condition report that their health is poor/fair; however, 4% report fair/poor health without acknowledging that they have a chronic condition. As expected, lower levels of income and education impact upon health status reports. Of the respondents stating that they have a child in the home, 14% report that their health is poor/fair.



### Status of Respondents with Fair or Poor Health (13%)

Age		Gender		Region		Family Physician?		Income	
18-34	8%	Male	17%	Urban	12%	Yes	14%	Under 40K	27%
35-54	10%	Female	13%	Rural	18%	No	6%	40-60K	16%
55+	20%							60-80K	17%
								80-100K	7%
								100K+	3%
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Children < 18		Chron. Cond'n?		Work in HC?		Education			
Yes	14%	Yes	38%	Yes	7%	HS or Less	21%		
No	39%	No	4%	No	14%	College	12%		
						University	6%		



30% of our respondents reported that they have a chronic disorder with 29% of them reporting that they have two chronic disorders and 15% having three or more. We tend to think of chronic disorders as diseases that are diagnosed as people age; however, amongst those reporting that they have a chronic disorder, 17% are young adults, 25% are middle aged and 47% are over the age of 55. More women than men report having one or more chronic disorders. While the impact of income and education on the reports of chronic diseases is not as strong as self-reports of

fair/good health, the gradient holds true. Respondents with children under the age of 18 are not immune to coping with one or more chronic disorders nor are healthcare workers. 16% of those with children and 26% of those working in healthcare report one or more chronic disorders. It is important to note that 17% of people reporting one or more chronic disorders do not have a family doctor. In addition, having a chronic disorder(s) does not correlate with reports of fair/poor health (i.e. 30% reported one or more chronic disorders and only 13% report that their health is fair to poor). The right supports in place means that one can live well a chronic disorder. Having a family doctor, a good education and positive earning power makes living well with chronic diseases a distinct possibility and provides an important message for government and the healthcare system.

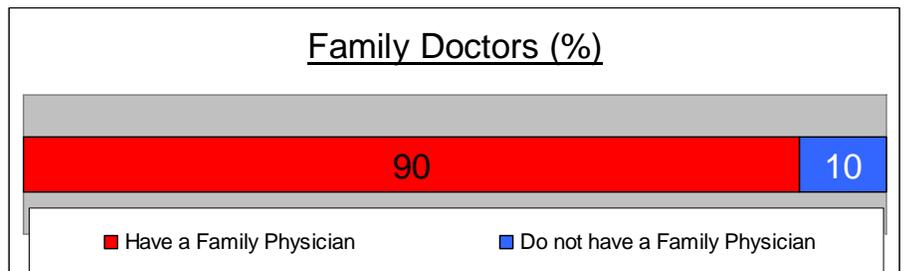
Respondents Indicating a Chronic Disorder							
Age		Gender		Region		Family Physician?	
18-34	17%	Male	28%	Urban	30%	Yes	31%
35-54	25%	Female	32%	Rural	30%	No	17%
55+	47%						
Children Under 18		Income		Work in HC?		Education	
Yes	16%	-40K	46%	Yes	26%	High School	32%
No	39%	40-60K	34%	No	30%	College	30%
		60-80K	23%			University	28%
		80K+	24%				

In reviewing the data regarding individuals that report having *three or more chronic disorders* (i.e. 15% of those reporting a chronic disorder), it should be noted that 7% of them do not have a family doctor and 7% of them are in the younger age group and an equal number are in the middle age group. 10% of them have children under 18 and 15% of them work in healthcare. The income/education gradient is weak amongst this group.

Status of respondents with 3 or more chronic conditions (15%)							
Age		Gender		Region		Family Physician?	
18-34	7%	Male	15%	Urban	16%	Yes	15%
35-54	7%	Female	15%	Rural	8%	No	7%
55+	23%						
Children Under 18		Income		Work in HC?		Education	
Yes	10%	-40K	17%	Yes	15%	High School	21%
No	16%	40-60K	23%	No	15%	College	5%
		60-80K	11%			University	28%
		80-100K	7%				
		100K+	13%				

An improvement in the number of people reporting that they do not have a family doctor was seen in this survey. Previously, it was in the 15% range; this survey demonstrated a rate of 10%. Dr. Barbara Starfield’s research demonstrates that positive health outcomes, equitable access and reduced costs amongst various countries and various

An improvement in the number of people reporting that they do not have a family doctor was seen in this survey. Previously, it was in the 15% range; this survey demonstrated a rate of 10%.



Dr. Barbara Starfield’s research demonstrates that positive health outcomes, equitable access and reduced costs amongst various countries and various

regions within countries are positively correlated with a high ratio of family physicians per population. The ratio of family physicians in Canada is one of the lowest amongst developed nations and Ontario has one of the lowest ratios in Canada. Canada used to boast the best healthcare system in the world. We are now amongst the middle ranging countries.

Respondents who do not have a family doctor tend to be younger, male, living in an

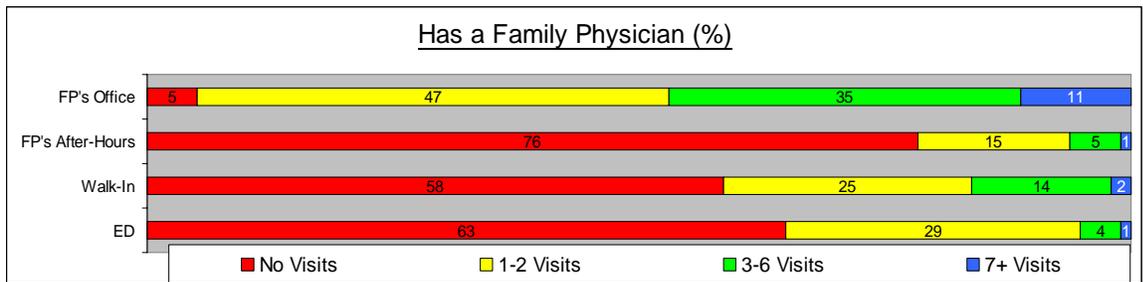
urban setting and with no children under the age of 18 in their home. Of specific concern are people with a chronic disorder (6%) who do not have a family doctor and especially those with three or more chronic disorders. When asked about their use of the healthcare system, people with a family doctor tend to be receiving primary care services. Only 5% had not seen that family doctor in the past year with the majority seeing their

Status of respondents without a family physician					
Age		Gender		Region	
18-34	14%	Male	11%	Urban	10%
35-54	10%	Female	8%	Rural	8%
55+	6%				

Status of respondents without a family physician							
Children Under 18		Income		Chronic Condition?		Education	
Yes	88%	-40K	14%	Yes	94%	High School	12%
No	11%	40-60K	7%	No	6%	College	9%
		60-80K	10%			University	8%
		80-100K	10%				
		100K+	7%				

family doctor

one or two times per year. 35% had had 3-6 visits and 11% had had



more than 7 visits. The impact of these heavy users of healthcare on the more expensive parts of the system (i.e. Emergency Departments and Walk-In Clinics) would have increased costs exponentially. The heavy users of family physicians

offices (i.e. 6 visits or more) tend to be women, patients living in rural communities and those with chronic conditions.

Heavy-users of the system							
Age		Gender		Region		Children Under 18?	
18-34	10%	Male	8%	Urban	11%	Yes	9%
35-54	12%	Female	14%	Rural	15%	No	0%
55+	12%						

The use of After-Hours Clinics, Walk-In Clinics and EDs is heavily skewed towards the younger,

Heavy-users of the system							
Chronic Condition?		Income		Work in HC?		Education	
Yes	23%	-40K	28%	Yes	9%	High School	17%
No	9%	40-60K	0%	No	0%	College	11%
		60-80K	14%			University	8%
		80-100K	6%				
		100K+	3%				

employed patient population. This finding speaks to the need for better after-hours access.

The heavy use of the expensive parts of the system by patients with a family physician is lower than those without a family doctor. Heavy-users of Walk-In Clinics and EDs tend to be older, live in urban settings and have chronic conditions.

Use by heavy-users (i.e. 6 or more visits) of non-family practices by patients with a family physician

After-hours clinic	1%
Walk-in clinic	2%
Emergency	1%

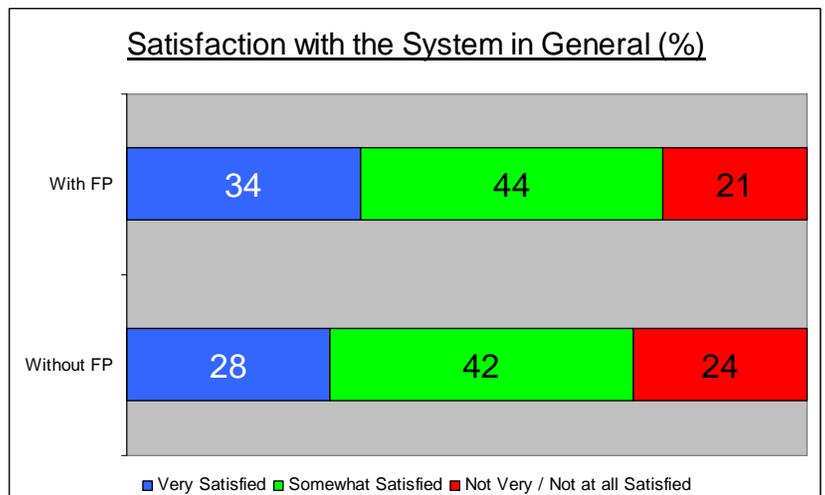
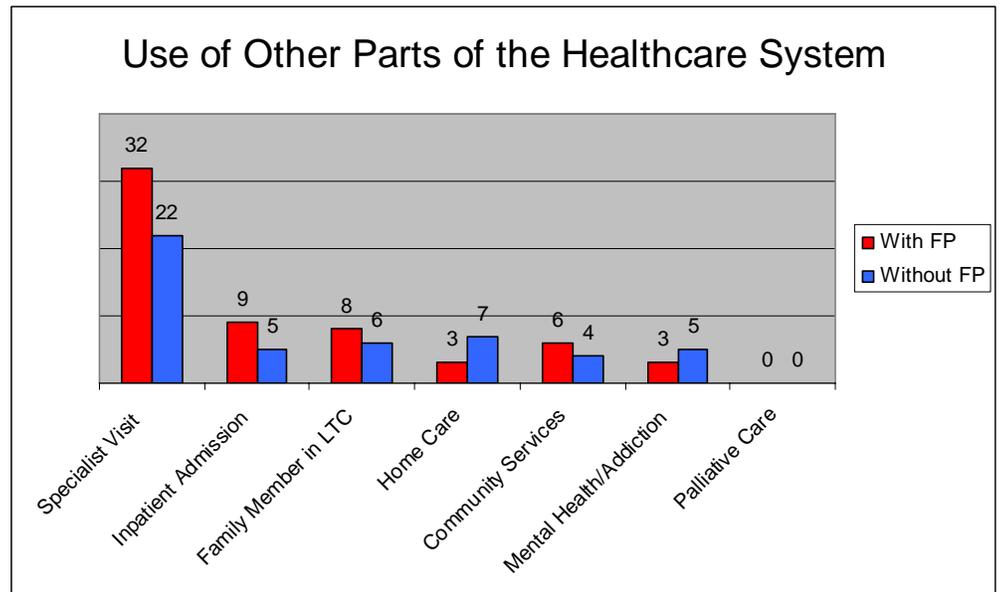
Percent of heavy-users (i.e. 6 or more visits) of walk-in clinics for patients without a family physician

Walk-in clinic	9%
Emergency	3%

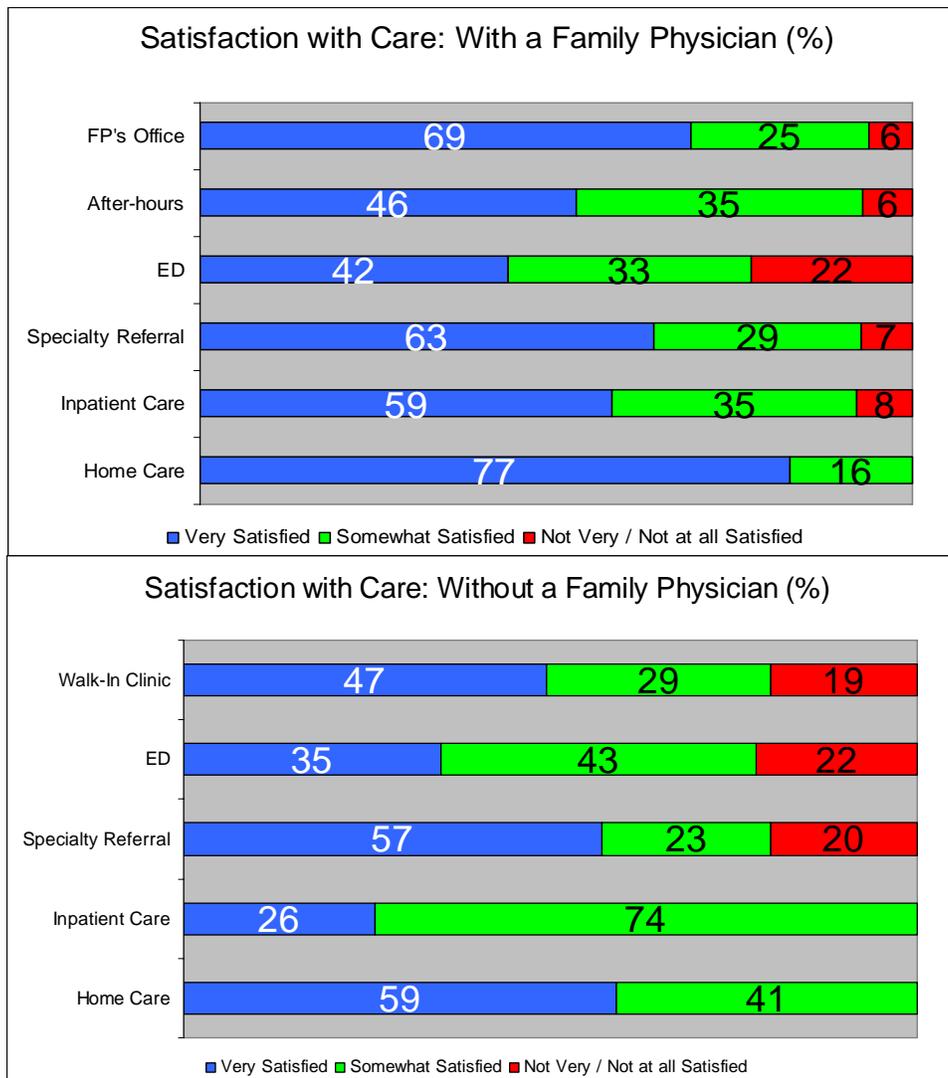
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People with a family doctor tend to have better access to the rest of the healthcare system. The older, sicker population with a family doctor tends to be referred to specialists more frequently, have more in-patient visits, have better access to community services, and are more likely to have a family member in an LTC facility.

More people without a family doctor report receiving homecare. Since 80% of all mental health and addiction care is delivered in family practices, it is not surprising that more people without a family doctor report receiving these services in the mental health/addiction sector. While having a family doctor has an



**impact on satisfaction with the healthcare system in general, the impact on satisfaction is particularly noteworthy on satisfaction with emergency visits, specialty referrals, inpatient care and home care.**

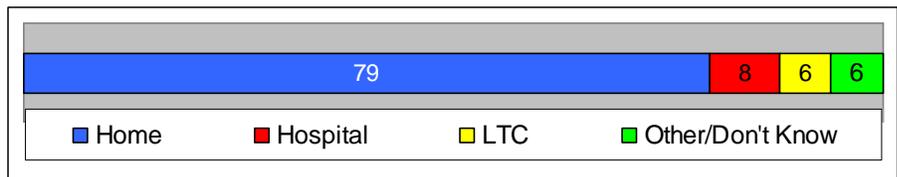


**In asking respondents about their expectations for the healthcare system in the future, the key messages received are as follows:**

- Future Healthcare System Expectations**
- 85% expect that the healthcare system will ensure that they and their family members will have a family doctor in the future
  - 91% of those that expect to have a family doctor anticipate that the majority of their care and their family members' care will be delivered by their family doctor's practice
  - For those who do not expect to have a family doctor, they expect to receive their care in a Walk-In Clinic (58%) or an Emergency Department (48%) with a significant number expecting direct access to specialists when needed (48%) and to care in their own homes (44%) or a long-term care facility
  - 40% of respondents do not have access to a family physician afterhours or on weekends now. Only 44% expect to have such access in the future

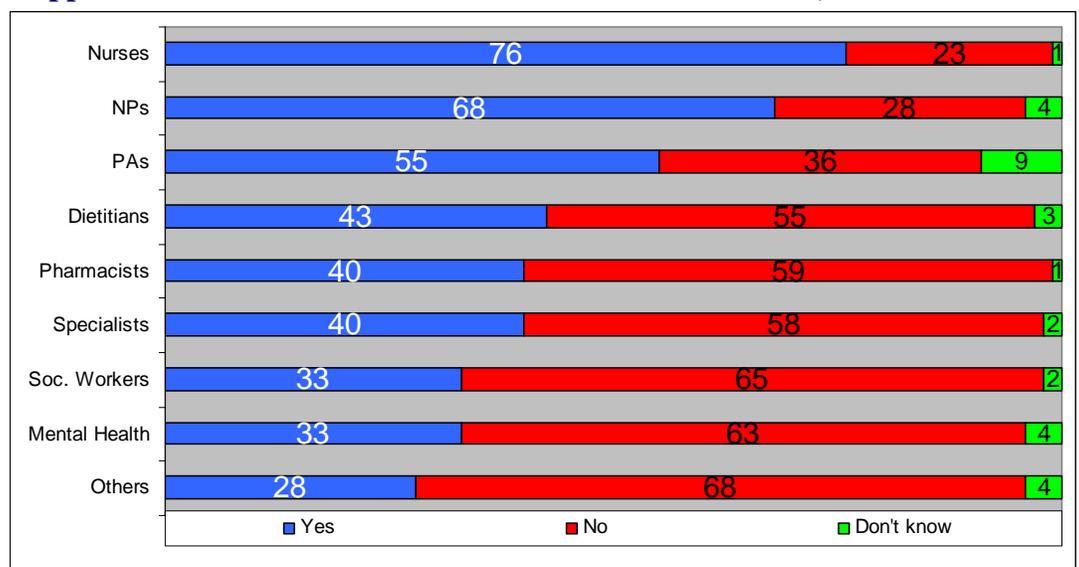
When this survey was conducted, there was a great deal of media attention being paid to the sustainability of the system and the shortage of family doctors across Canada. The surveys reflect the public’s concern that there will be a continued and deepening shortage of family doctors as the current generation of senior physicians retires. Only 85% of people expect the government to ensure that they have a family physician in the future. The majority of the 15% who do not expect to have one in the future do not have one now. They expect to receive their care in Walk-In Clinics and Emergency Departments. The sustainability of the system rests with finding alternatives to Walk-In Clinic/Emergency Department use for non-urgent problems (i.e. increased access to family doctors and their practice teams). For those who did have a family doctor, they expect that their family physician will deliver the majority of their care in their own family practice, with 40% reporting that they had limited access to their family doctor after hours and only 44% expecting that to change.

Respondents overwhelmingly identified their preference for home-based care if they or a family member became frail and needed nursing care. The preference for a hospital bed versus a long-term care facility was an interesting finding and probably related to media in regards to care deficits in the sector and in rest homes.



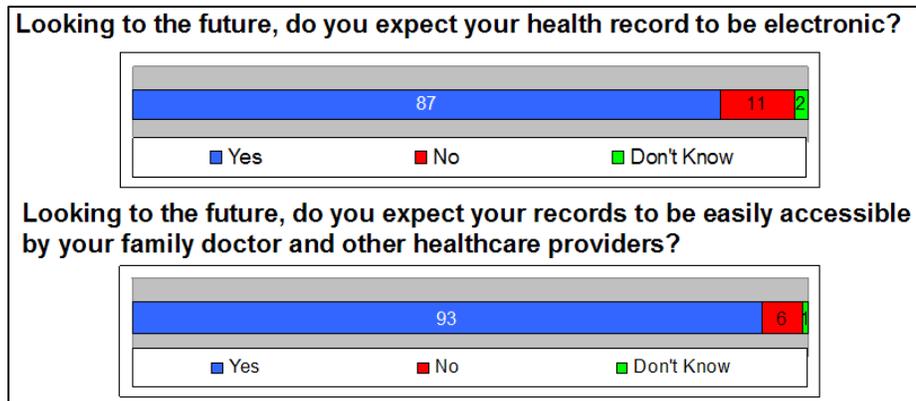
A second question in regards to the future system asked respondents about the healthcare professionals that they expect to be working in family practices. Respondents were supportive of team-based care and it was noted that nurses, nurse practitioners and physician assistants were most likely to be identified as key healthcare professionals in the practices.

While family doctors would agree with this ranking, they see social workers/mental health workers and specialists as vital to team-based practices, while the public thinks of dietitians, pharmacists and specialists as team members.

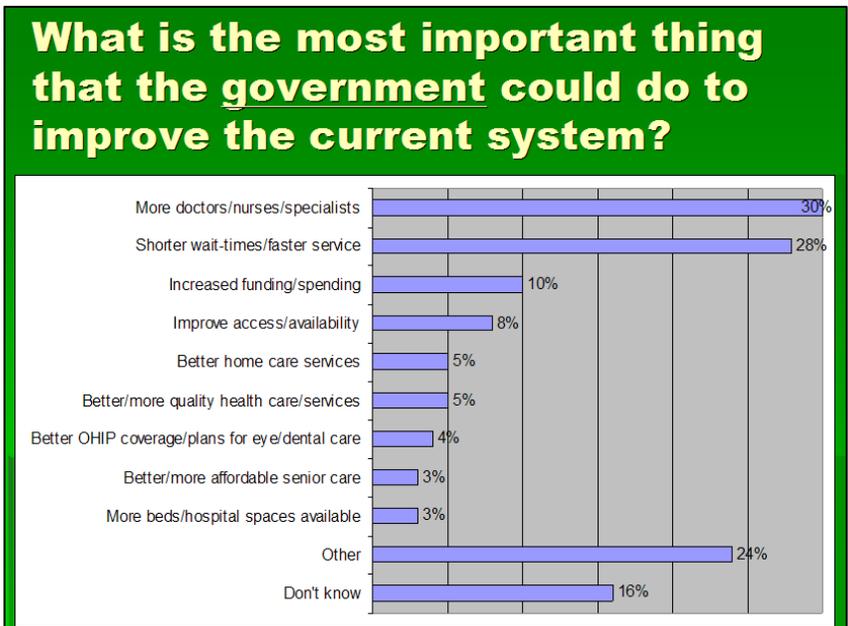


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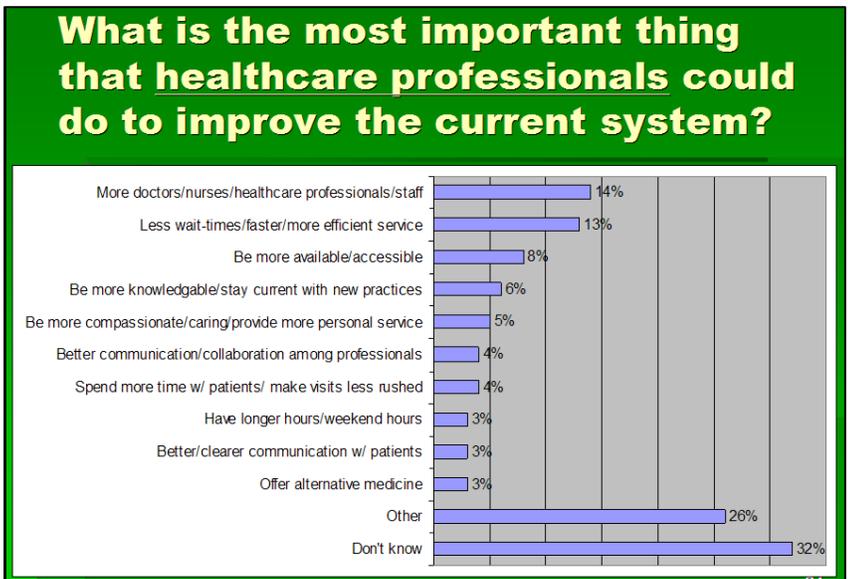
Information technology was resoundingly supported by the public with 87% expecting their health records to be electronic and 93% expecting them to be easily accessible to their family doctor and other healthcare providers.



Given the emphasis in the media on the shortage of family doctors at the time of the survey, it was not surprising that the number one item identified as the most important thing that government could do to improve the current system was to increase the number of family doctors, nurses and specialists in the system. In spite of the media in regards to the sustainability of the system, respondents want shorter wait-times/faster services, better access and availability of services and more of every service including services that are not currently covered by OHIP.



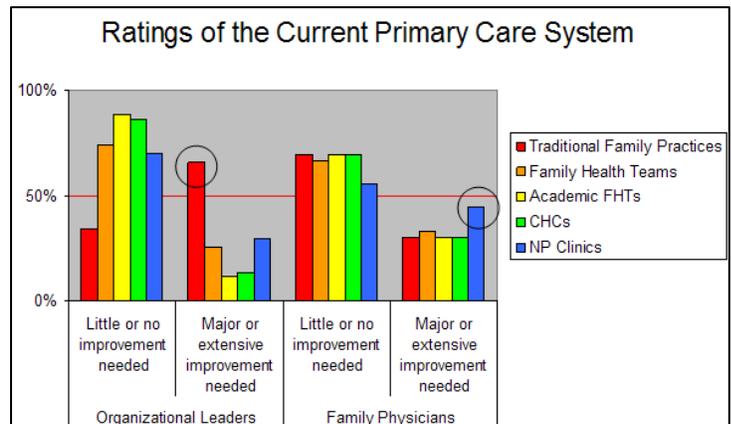
Advice to healthcare professionals in terms of what they can do to improve the system showed the same trend to a system that may cost even more if we do not find ways to assist the public to have their needs versus their wants addressed and especially if we do not find further efficiencies in the system.



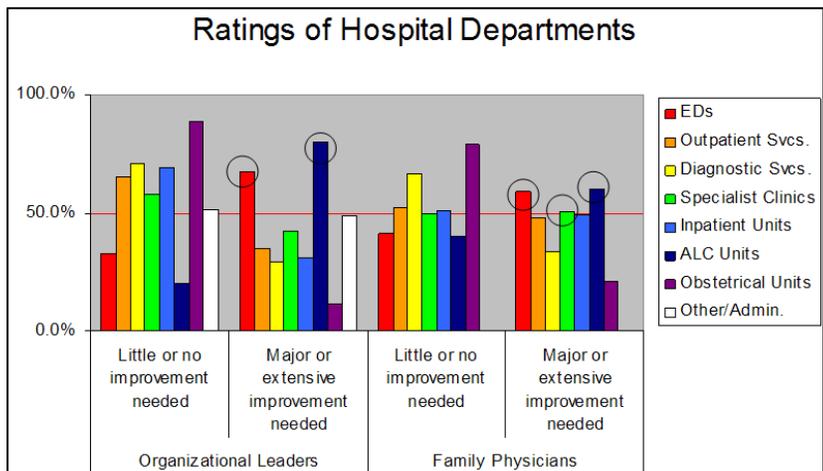
## The Survey Results of Organizational Leaders Compared with Family Physicians

The comparisons of organizational leaders with family physicians reveal some interesting findings.

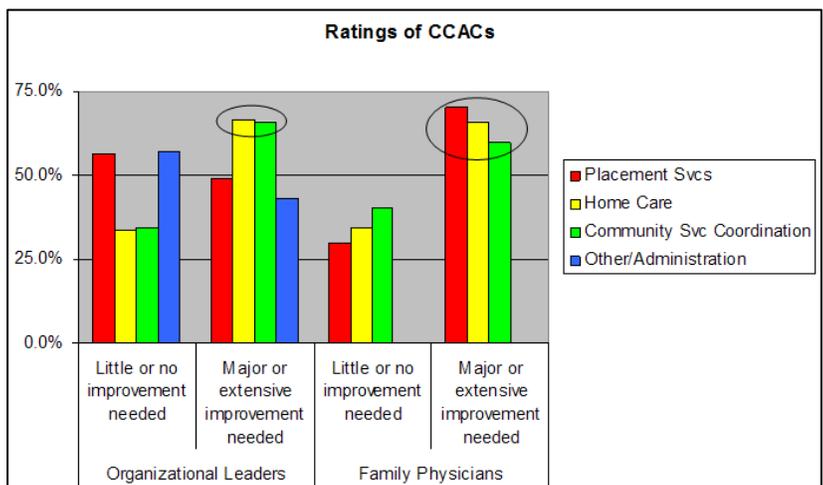
Organizational leaders tend to believe that the current non-interprofessional models of family practice need major or extensive improvements while the physicians tend to look less favourably on the NP clinics.



Both groups agree that Emergency Departments and ALC Units need improvement; however, family physicians also expressed concerns regarding specialty clinics/outpatient clinics, with access being a problem.



Where CCACs are concerned, organizational leaders noted improvements in placement services whereas the community-based physicians expressed concerns regarding their difficulties in having their patients placed directly into an LTC facility. Both groups identified resource issues for the provision of home care as problematic. There is an apparent need to greatly improve homecare, given the responses from the public about wanting care in their own homes as they become frail. As well, both groups see community service coordinating as an area for improvement amongst the CCAC case workers.



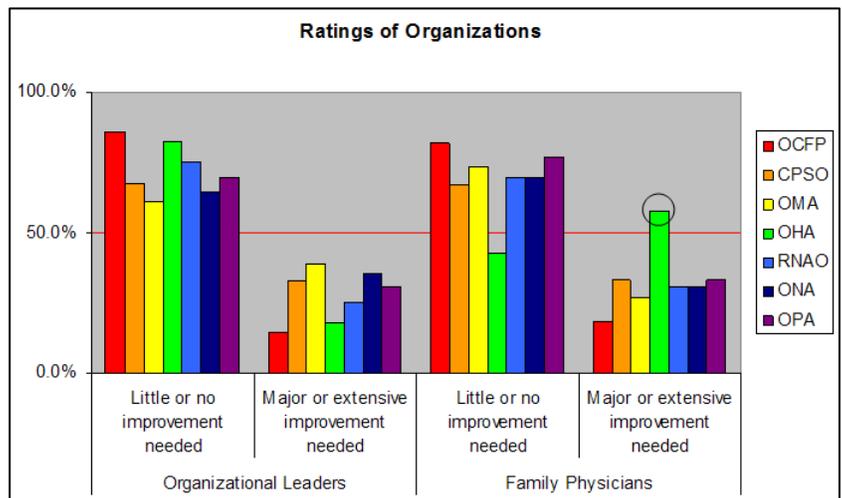
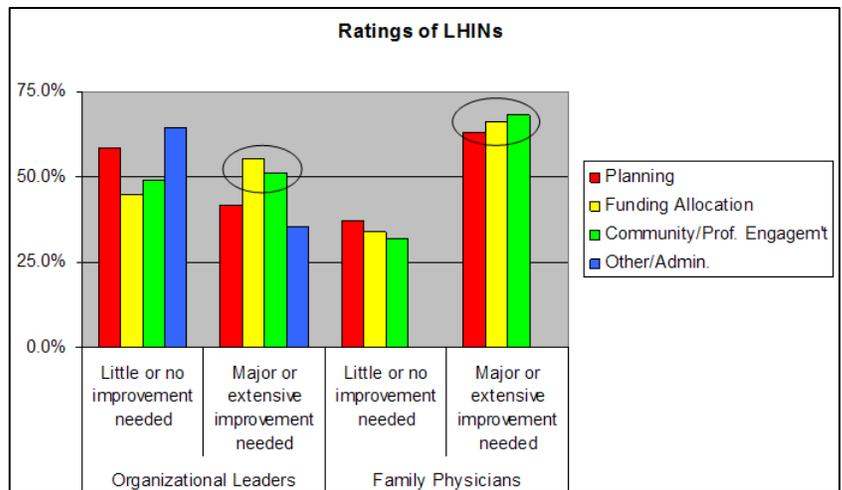
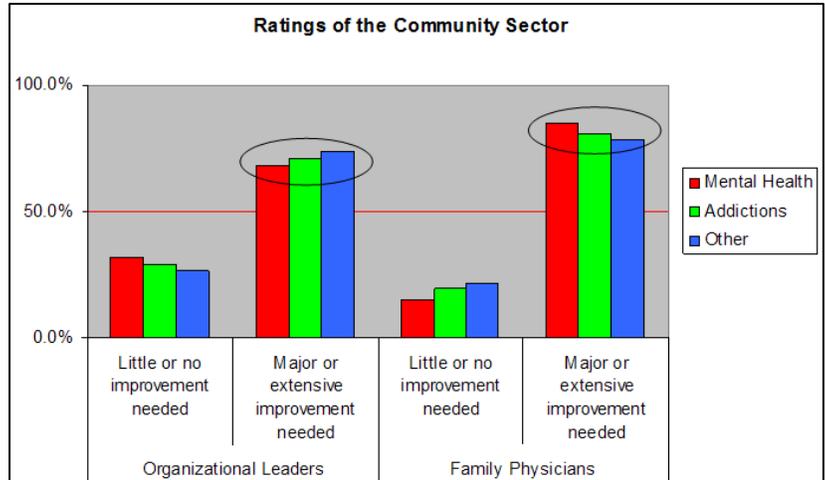
In the community sector, both groups agree that mental health and addictions services, indeed all other community-based services, need to be better resourced and coordinated.

As far as the LHINs are concerned, organizational leaders suggested improvements are needed in funding allocations and community and professional engagement; however, the physicians suggested

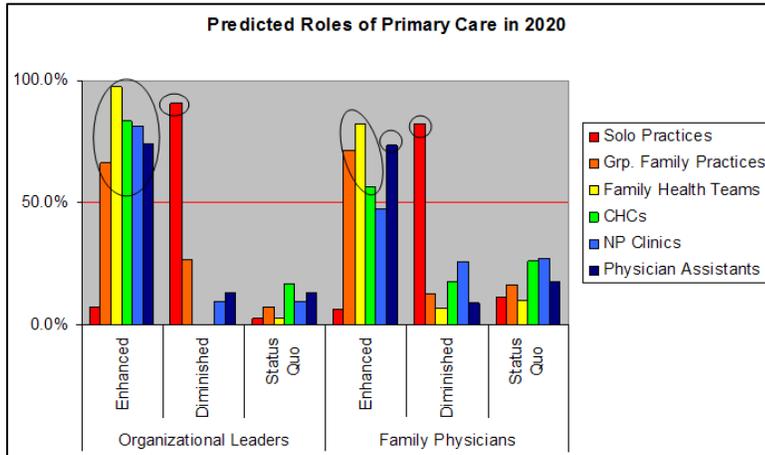
improvements needed in all areas of LHIN responsibilities. Many of the comments from the physicians could be summed up by the statement “What is a LHIN? What do they do anyway? Aren’t they just another layer of MOHLTC bureaucracy?”

The OCFP was pleased to be seen by the majority of both organizational leaders and our own Members as needing little or no improvement. This survey was conducted during a period when the OHA’s Hospital Prototype Bylaws were very much in the news, so OCFP Members respect for the OHA was a less than optimal. One of the common comments amongst our members was that they really did not know how well many of the non-medical organizations actually functioned and some of the comments from both groups were that the

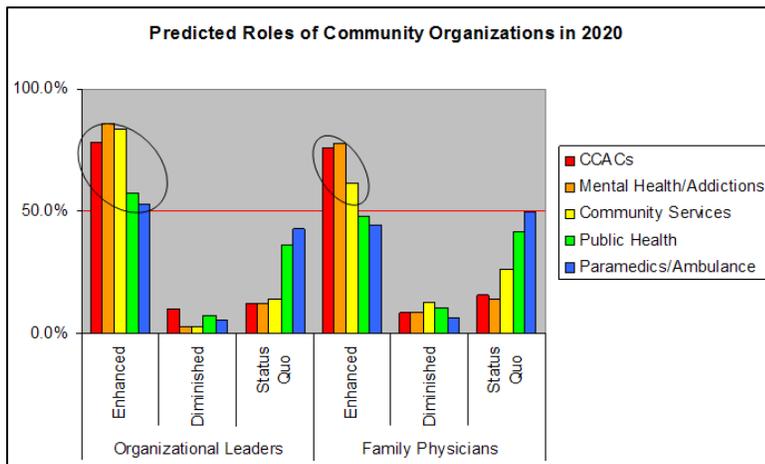
organizations served their own members well but may not always serve the system well in this era of collaboration and partnership. The OCFP was pleased that it received plaudits in this area of collaboration.



**The opinions of organizational leaders and family physicians in regards to the roles various components of the primary care system will play in the future were captured in this graph. Both groups saw a diminished role for solo practices with the physicians seeing an increased role for both group practices and FHTs, and an increased reliance on PAs, with less support for NP Clinics than the organizational leaders forecast.**

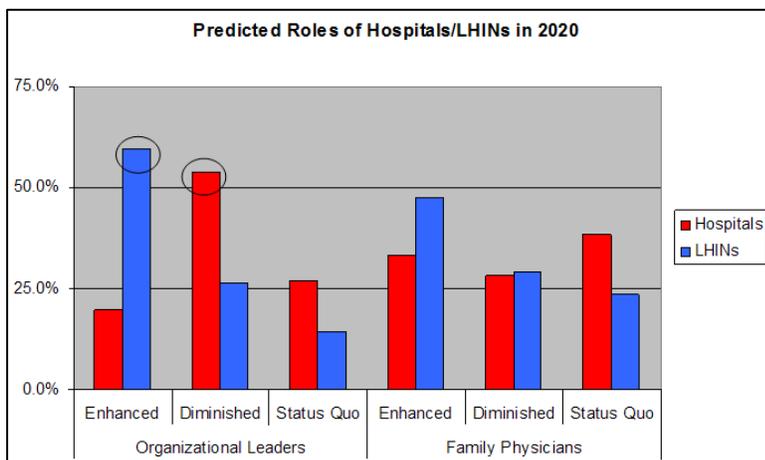


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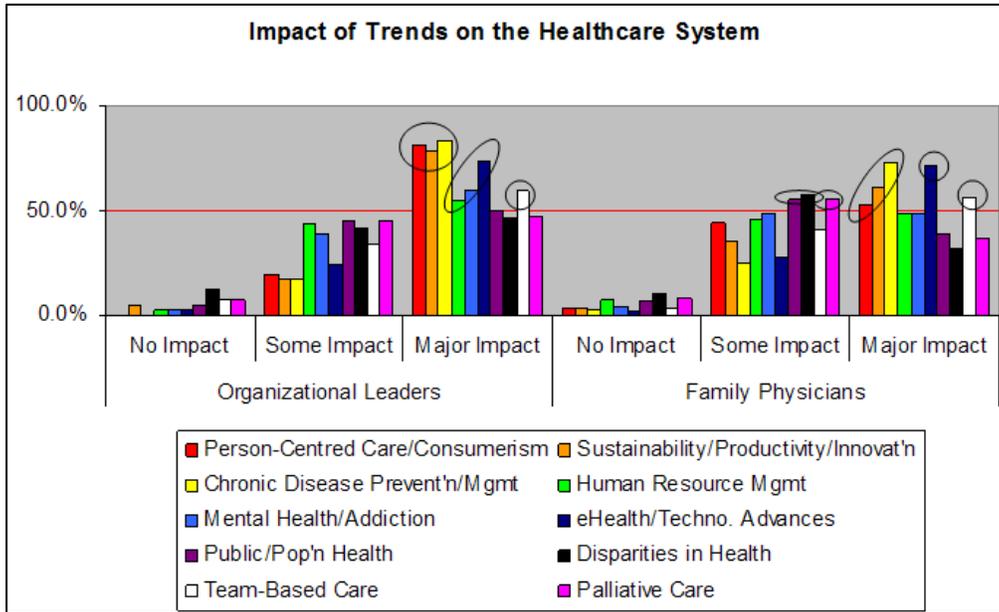
The difference between the ratings of organizational leaders and family physicians in regards to community organizations was fairly insignificant; however, with more resources for health protection and promotion in family practice, some of the family physicians saw a decreased role for public health. They remain concerned about the role

**Public Health Units played during H1N1. Organizational leaders were a little more knowledgeable about the impact of centralization of services or ambulances/paramedics than family doctors.**



Organizational leaders are forecasting a diminished role for hospitals and an enhanced role for LHINs, whereas family physicians are divided on how hospitals and LHINs will function in the future – and their comments about LHINs reflect a lack of understanding of their roles in the system.

The majority of both organizational leaders and family physicians identified that each of the trends would have an impact. Organizational leaders tend to believe that the majority of them would have a major impact. Both groups saw Person-Centred Care and Consumerism, Chronic Disease Management, Sustainability, e-Health and Team-Based Care as having the most impacts. Organizational leaders saw Human Resource Management and Mental Health and Addictions as other issues that have major impacts on the system. The differences, according to the comments, tend to relate to the current experiences of family physicians in providing patient-centred care and dealing with mental health and addictions problems in their practices already.



In summary, there is a wealth of information in these surveys that we will continue to mine over the course of time.